Dr. Egg Pediatric Dentistry

QUESTIONNAIRE FOR PARENTS OF SPECIAL PATIENTS

PATIENT NAME____ DATE____________

In order for us to get to know your child better, we would appreciate you taking time to complete this questionnaire. There may be some duplicate questions that coincide with our general health history form; if the answer is extensive, please make a note that refers our office to the correct form. Thank you VERY much for the extra time you took!

1) What is your child's diagnosed medical condition(s)?

2) When was this condition first diagnosed/discovered?

3) If your child sees a specialist(s) for this condition, please list their names and phone numbers:

Doctor's Name	**Specialty Field**	**Phone #**

4) Birthday: ________ What is your child's exact age in years and months? ___ years ___ months

5) What is your child's approximate developmental age? ________ years

6) At what level does your child communicate verbally?
____no delay ____mild delay ____moderate delay ____does not speak

7) Is your child receiving medication for the condition and, if so, which medications is your child currently taking, and the dosage? ____NO MEDICINES ____YES *(*please list info*)*

8) Has your child's physician told you that your child needs to be premeditated (antibiotic coverage) before dental services can be provided? ____NO ____YES *(*if "yes", confirm that your child's pediatric cardiologist's name and office number are listed in Question 3)

9) Does your child have any allergies to medicines, blood disorders, or heart problems? If so, please explain.

10) Is this your child's first visit to a dentist? ____NO ____YES

11) Has your child had any negative dental experiences and, if so, please describe?
_____NO _____YES

12) What does your child like to do? Hobbies, favorite foods, etc.?